STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395685	A. BLDG: 00 B. WING:	04/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **230102**	**115 S PROVIDENCE ROAD WALLINGFORD, PA 19086**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0000	Continued from page 1 Based on an Abbreviated Survey in response to three complaints, completed on April 4, 2023, it was determined that Wallingford Nursing and Rehabilitation Center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		

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F 0000	Continued from page 2 .	F 0000		
F 0582 SS=D		F 0582		

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F 0582 SS=D	Continued from page 3 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation	F 0582	Plan of Correction 1. Resident R1 was discharged from the facility and has not returned to the facility. A NOMNC was provided to the resident. 2. An audit was completed last 30 days by social services director or designee for short term care residents to confirm the facility provided a signed copy of the SNFABN and NOMNC letter for residents for prior to discontinuation of Medicare coverage 3. NHA Reeducated Social Services on the requirement of notification of SNFABN and NOMNC letters for residents prior to discontinuation of Medicare coverage. 4. Social Services/ Designee will audit residents who had Medicare benefits discontinued to ensure that the letter was signed and completed of the SNFABN and NOMNC letter for residents prior to discontinuation of Medicare coverage weekly X 4 weeks, Biweekly X 2 and Monthly X 2. Results of audits will be submitted to the QAPI committee for review.	Completion Date: **05/18/2023** Status: **APPROVED** Date: **04/18/2023**

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F 0582 SS=D	Continued from page 4 of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582		

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F 0582 SS=D	Continued from page 5 Based on a review of facility policies and procedures, record review, and staff interview, it was determined that the facility failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage and Notice of Medicare Provider Non-Coverage was provided to one of three residents reviewed. (Resident 1) Findings include: Review of the form entitled "Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)" states that this notice is given to make residents aware of care that no longer meets Medicare coverage requirements and they may have to pay out of pocket for the care listed. The provider must ensure that the beneficiary or their representative signs and dates the SNFABN to demonstrate that the beneficiary or their representative received the notice of possible out of pocket costs.	F 0582		

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F 0582 SS=D	Continued from page 6 The form "Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123," (notice that informs the recipient when care receive from skilled nursing facility is ending and how you can contact a Quality Improvement Organization (QIO) to appeal) instructs that a Medicare provider must be delivered at least two calendar days before Medicare covered services end. The provider must ensure that the beneficiary or their representative signs and dates the NOMNC to demonstrate that the beneficiary or their representative received the notice and understands the termination of services can be disputed. Review of Resident 1's clinical record revealed the resident ended Medicare part A coverage on February 4, 2023 and became private pay. Further review of Resident 4's clinical record revealed no evidence Resident 4's Power of Attorney or Responsible Party were notified of the change in payment source.	F 0582		

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F 0582 SS=D	Continued from page 7 Interview with Licensed social worker E3 on April 4, 2023, at 2:00 p.m. confirmed the facility was unable to provide a signed copy of the SNFABN and NONNC letter for Resident 4 prior to the discontinuation of Medicare coverage. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.18(e)(1) Management Previously cited 10/24/2017 28 Pa. Code 201.29(a) Resident rights	F 0582		
F 0690 SS=D		F 0690		

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F 0690 SS=D	Continued from page 8 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Plan of Correction 1. Resident R2 care plan for urinary incontinence was implemented to ensure proper care and service. Resident R2 had a urinary and bowel incontinence evaluation completed to reflect their current urinary incontinent status. 2. An audit was conducted by the Director of Nursing for all current residents regarding care plans and urinary and bowel incontinence assessments to ensure residents admitted, readmitted and with a change of condition receive the appropriate incontinent care. 3. Licensed Nursing staff will be reeducated by the Director of Nursing (DON) or designee on the importance of completing care plans to address urinary incontinence and urinary and bowel incontinence assessments to ensure the best quality of care for the resident. 4. DON or Designee will audit residents' records to confirm urinary incontinence care plans are in place, and urinary and bowel incontinence	Completion Date: **05/18/2023** Status: **APPROVED** Date: **04/18/2023**

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F 0690 SS=D	Continued from page 9 This REQUIREMENT is not met as evidenced by:	F 0690	assessments are completed on admission, readmission, and with significant changes. Audits will be conducted weekly X 4 weeks, Biweekly X 2 and Monthly X 2. Results of audits will be submitted to the QAPI committee for review.	

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F 0690 SS=D	Continued from page 10 Based on facility policy and procedure and clinical record review, and staff interview it was determined the facility failed to provide care and services to improve or maintain continence status for one of four residents reviewed. (Resident 2) Findings Include: Review of facility policy titled Continence Management, revised June 15, 2022, revealed patients will be assessed for the need for continence management as part of the nursing assessment process. A urinary incontinence assessment and/or bowel incontinence assessment will be completed upon admission or re-admission and with a change in condition or change in continence status. Continence status will be reviewed quarterly as part of the care planning process. Review of Resident 2's diagnosis list revealed Resident 2 was admitted to the facility on December 12, 2022, with a diagnosis of Cerebral Infarction	F 0690		

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F 0690 SS=D	Continued from page 11 (stroke) and Hemiplegia of dominate right side (paralysis). Review of Resident 2's quarterly Minimum Data Set (MDS-periodic assessment of resident needs), dated February 5, 2023, revealed the resident was always incontinent of bowel and bladder. Review of Resident 2's clinical record revealed there were no urinary and bowel assessment completed since admission. Review of Resident 2's care plan revealed there was no care plan for incontinence care or quarterly reviews of continence status. The facility failed to provide care and service to improve or maintained Resident 2's incontinence status. 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing	F 0690		

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F 0690 SS=D	Continued from page 12 services 28 Pa. code 211.10(a)(d) Resident care policies	F 0690		

Certified End Page

WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 230102

SURVEY EXIT DATE: 04/04/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY